Clinch Memorial
FAMILY PRACTICE

Dear Clinch Memorial Family Practice Patient:

Welcome to Clinch Memorial Family Practice. Thank you for allowing us the opportunity to assist with your health care needs. We value all of our patients and are committed to providing you with high-quality, health care services.

This packet includes all of the new patient forms that will need to be completed in order for us to assist with your care.

1. Patient Registration Form
2. Financial Policy Form
3. Insurance signature on file
4. Information release
5. Patient health history questionnaire
6. Notice of Privacy Practices
7. Records release (this form only needs to be completed if you have records at another physician office that Clinch Memorial Family Practice would need for the appointment)

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 15 minutes early for your appointment. Directions to the practice can be found on our Web site at www.clinchfamilypractice.org

The physicians and staff of Clinch Memorial Family Practice are looking forward to assisting you with your health care needs. If you have any questions, please call the practice at 912-470-2273 and someone will be happy to help you.

Sincerely,

Clinch Memorial Family Practice

Patient Registration Form

Clinch Memorial FAMILY PRACTICE

Patient Demographics

Patient Information

Last Name: First Name: M.I.: Preferred Name (if applicable)

Mailing Address: Apt#

City/State/Zip:

Home Phone: Cell Phone: Work Phone:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number:
☐ Home ☐ Cell ☐ Work

Sex: ☐ Male ☐ Female Date of Birth:

Marital Status: Social Security#:

Employer Name: Emergency Contact Name:

Emergency Contact Phone #: Relationship to Patient:

Guarantor Information

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name: First Name:

Date of Birth: Social Security#: Phone:

Address of Person Responsible:

City/State/Zip: Relationship to Patient:

Additional Information **(PLEASE Fill OUT ALL SECTIONS BELOW)**

Email Address: Can we leave a message regarding your medical care & test results?
☐Yes ☐No

Race (please select):
☐ White ☐American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐Decline

Ethnicity (please select one):
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Decline

Preferred Language (please select one): ☐English ☐ Bosnian ☐ Indian (including Hindi & Tamil)
☐Sign Language ☐ Spanish ☐Russian ☐Other

Preferred Pharmacy Name & **Location:**

Insurance Information

Primary Insurance	**Secondary Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security#:	Policy Holder's Social Security#:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I attest that the above information is complete and correct to the best of my knowledge.

Signature of Patient or Responsible Party:_____ Date: _____

Printed Name of Patient or Responsible Party:_____ Date:_____

Financial Policy

Clinch Memorial Hospital wants to provide our community with healthcare services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- You need to contact your insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at (912) 470-2401 at once so we can help you with this problem. Clinch Memorial Family Practice will help to arrange a payment plan.
- Any bill not paid by the date it is due will be sent to a collection agency

IF **YOU <u>DO NOT</u> HAVE HEALTH INSURANCE**

<u>Your Responsibility</u>

- You must pay your entire bill at the time of service.

<u>Our Responsibility</u>

- We are willing to talk to you about ways to pay, if you cannot pay the full amount.

IF YOU HAVE HEALTH INSURANCE

We *participate* with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits.

*If we **DO** participate with Your insurance plan (including Medicare):*

<u>Your Responsibility</u>

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance within 30 days of getting your bill. If you do not pay or make payment arrangements, we will begin collection efforts after 90 days of getting your bill.

<u>Our Responsibility</u>

- We will send a bill to your insurance company for all services done in our offices.

If we DO NOT participate with your insurance plan:

Your Responsibility

I. You must pay for the service at the time it is given

To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover, and Debit cards. We will charge you a $35.00 fee for any returned checks.

Our Responsibility

II. After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from Clinch Memorial Family Practice must pay any charges that are not paid by insurance or any other party.

Other providers, such as x-ray or laboratory, will bill the patient separately.

The patient must pay any amount not paid by insurance, within (30) days of receiving the bill. If Clinch Memorial Family Practice needs to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all fees and costs to Clinch Memorial Family Practice by the agency or attorney.

By signing this form, I acknowledge that I have read and understand the financial policy in its entirety.

Patient/Responsible Party Signature: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Clinch Memorial
FAMILY PRACTICE

INSURANCE SIGNATURE ON FILE

PATIENT'S NAME_____DOB#_____

INSURANCE COVERAGE

I request that payment of authorized Commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to the Clinch Memorial Family Practice for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

_____ _____
Primary Identification Number Secondary Identification Number

_____ _____
Primary Insurance Secondary Insurance

_____ _____
Date Signature of Patient (or Parent, if patient is a minor)

****

_____ _____
Primary Identification Number Secondary Identification Number

_____ _____
Primary Insurance Secondary Insurance

_____ _____
Date Signature of Patient (or Parent, if patient is a minor)

****

_____ _____
Primary Identification Number Secondary Identification Number

_____ _____
Primary Insurance Secondary Insurance

_____ _____
Date Signature of Patient (or Parent, if patient is a minor)

Clinch Memorial
FAMILY PRACTICE

Permission to Release Diagnostic/Medical Information to another Individual

Effective Date:* _____

Print Patient's Full Name: _____

Patient's Date of Birth: _____ MR#: _ _ _ _ _ _ _

I give Clinch Memorial Family Practice entities permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I give Clinch Memorial Family Practice entities permission to leave any protected health information on an answering machine or voicemail.

☐ **Yes** ☐ **No**

Indicate your relationship to the patient: ☐ **Patient** ☐ **Patient Representative**

_____

Print Name ***(if other than patient)***

_____

Signature **Date**

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name:_____ **Sex: M** / F **DOB:**_____ **Date:**_____

List All Prescriptions and over-the-counter medications, supplements and vitamins you take including the dose or strength and frequency.

Allergies: _____

Latex Allergy: Yes / **No**

Preferred Pharmacy:_____

PAST MEDICAL IDSTORY

Do you have now or have you ever had any of the following?

Heart Disease	Yes	No	Hyperthyroid	Yes	No
Heart Attack	Yes	No	Kidney Stones	Yes	No
Heart Arrhythmia	Yes	No	Kidney Disease	Yes	No
Atrial Fibrillation	Yes	No	Stroke	Yes	No
Congestive Heart Failure	Yes	No	Gallbladder Disease	Yes	No
Hypertension	Yes	No	Anemia	Yes	No
Vascular Disease	Yes	No	Chronic Back Pain	Yes	No
Diabetes	Yes	No	Rheumatoid Arthritis	Yes	No
* Insulin Dependent	Yes	No	Lyme Disease	Yes	No
* Non-Insulin Dependent	Yes	No	Psoriasis	Yes	No
High Cholesterol	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Neuropathy	Yes	No
Reflux Disease (GERD)	Yes	No	Hypothyroidism	Yes	No
Ulcers	Yes	No	Fibromyalgia	Yes	No
Cancer (location)	Yes	No	Colitis	Yes	No
Blood Clots (DVT or PE)	Yes	No			

Other: _____

PAST SURGICAL HISTORY

Please list any operations you have had:

FAMILY/SOCIAL HISTORY

Occupation: _____ Marital Status: Single Married Widowed Divorced

Your personal habits: Do you?			**Do you have a Family History of:**			**Relationship**
Exercise Regularly	Yes	No	Heart Disease	Yes	No	_____
Smoke or use Tobacco	Yes	No	High Blood Pressure	Yes	No	_____
* How much			Diabetes	Yes	No	_____
* For how many years			Stroke	Yes	No	_____
Used tobacco in the past	Yes	No	Cancer	Yes	No	_____
Drink Alcohol	Yes	No	Thyroid Disease	Yes	No	_____
*How much			Depression	Yes	No	_____
Recent Tick Bites	Yes	No	Blood Clots	Yes	No	_____

REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms?

Backache	Yes	No	Bloody Sputum	Yes	No
Leg Pain	Yes	No	Indigestion	Yes	No
Painful Joints	Yes	No	Abdominal Pain	Yes	No
Headaches	Yes	No	Diarrhea	Yes	No
Double Vision	Yes	No	Constipation	Yes	No
Difficulty Swallowing	Yes	-No	Change in Bowel Habits	Yes	No
Hoarseness	Yes	No	Slow Urine Stream	Yes	No
Nosebleeds	Yes	No	Abnormal Bleeding	Yes	No
Shortness of Breath	Yes	No	Blood in Stool	Yes	No
Dizziness	Yes	No	Pus in Urine	Yes	No
Chest Pain/Pressure	Yes	No	Yellow Jaundice	Yes	No
Irregular Heartbeat	Yes	No	Depression/Anxiety	Yes	No
Swelling of Feet	Yes	No	Weight Gain	Yes	No
Cough	Yes	No	* How many pounds		
Wheezing	Yes	No	Weight Loss	Yes	No
Vomited Blood	Yes	No	* How many pounds		

Patient Signature (parent for minor) Date Provider Signature Date

Clinch Memorial FAMILY PRACTICE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health Information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice *of* privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer 1050 Valdosta Hwy Homerville, GA Phone: (912) 487-5211

C. Uses and Disclosures of Health Information

For Treatment: We may use medical Information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company or a third party.

For healthcare operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to ensure anonymity.

D. Other Disclosures

Business Associates: We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Communication with others involved with your care: Our health professionals may, In the event you are incapacitated or in an emergency circumstance, using their judgment disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose health Information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

Required by law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.

Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, Injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled or withdrawn, needs repairs or replacement
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are require or authorized by law to disclose this Information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform 1heir jobs.

Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (II) the use or disclosure of your PHI Is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent or lessen the threat.

Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military commend authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President other officials or foreign heads of state, or to conduct investigations.

Inmates: our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the health, safety and security of the institution, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws,

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.

We will not use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

E, YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular-manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing using the contact information below. Your request must describe in a clear concise fashion:

{a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment** you may ask us to amend your health information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request and reason for the

request must be made in writing using the contact information below. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures:** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing using the contact information below. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date the "accounting of disclosures" is requested and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time by contacting us utilizing the contact information below.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Contact Information:

Privacy Officer 1050 Valdosta Hwy, Homerville, GA Phone: (912) 487-5211

Clinch Memorial
FAMILY PRACTICE

Notice of Privacy Practices Acknowledgement

I have received a copy of the Clinch Memorial Family Practice Notice of Privacy Practices. I understand that Clinch Memorial Family Practice has the right to change its Notice of Privacy Practices from time to time and that I may contact Clinch Memorial Family Practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name_____DOB:_____

Patient Signature:_____Date:_____

Legal Representative:_____

Date:_____

Relationship:_____

Date:_____

Clinch Memorial
FAMILY PRACTICE

AUTHORIZA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize:

☐ Receive from:_____

Address:_____

_____

☐ Disclose to:
Address: _____

_____

The following information regarding my

Please check all that apply

☐ Inpatient care on_____
Specify dates of admission/discharge

☐ Outpatient care on _____
Specify dates of clinic visits or outpatient procedure

☐ Emergency care on _____
Specify dates of Emergency Department visits

Please Check

☐Complete Medical Records
☐ Hospital Discharge Summary
☐Consultations_____
☐ Other *(please specify)* _____

☐History and Physical Examinations
☐Records from Other Providers (please specify)

☐ X-Ray, Imaging Reports
☐ Laboratory Reports
☐cardiac/EKG Reports

The purpose for disclosing the above information is indicated by a check mark (☑) below:

☐ Continuing care· ☐ Relocation ☐ Insurance ☐ Legal ☐ *Other (please specify)*_____

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

The signing of this authorization is not a condition for providing treatment.

I acknowledge and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information. _____(patient initials)

This authorization shall expire upon this expiration date _____. If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

My signature also acknowledges that I have read the above and authorize the disclosure of the protected health information stated. My signature also acknowledges receiving a copy of the document.

_____	_____	_____
Print Patient's full name	*Signature of Patient/Responsible Party*	*Date*
_____	_____	
Patient's Date of Birth	*Relationship to Patient*	
_____	_____	_____
Patient's Social Security Number	*Witness Signature*	*Date*

NOTE: THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETED IN ITS ENTIRETY.
A COPY OF THIS FORM WILL BE ACCEPTED IN LIEU OF AN ORIGINAL.
A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PATIENT OR PATIENT REPRESENTATIVE.

(over)

Patient Name: _____ DOB: _____

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

Verbal Consent requires Signatures of two witnesses

_____ _____
Signature of witness *Date*

_____ _____
Signature of witness *Date*